STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of the Connecticut Insurance Department 958

Before
The Insurance and Real Estate Committee

Tuesday, February 24, 2009

Raised Bill 958--An Act Concerning Utilization Review

The Insurance Department has significant concerns with this bill as drafted, and believes some of the changes may have unintended consequences that are not in consumers' best interests.

The bill deletes language that a clarification of coverage is not utilization review. We are not sure of the intent of the provision but it appears to include issues not related to medical necessity under the utilization review law. We believe the utilization review laws should continue to relate to medical necessity issues which also ties in with the external appeal law (as noted later in this testimony). If there are other issues, perhaps contract exclusions, that need more scrutiny, we suggest that such issues be clearly identified, and if appropriate, included in other legislation, rather than amend the utilization review law to include items that "don't fit." If the intent is to expand the law to include contractual denials, we believe this will disadvantage Connecticut group policyholders which have specifically negotiated and contracted with their group health insurer for specific benefits and specific exclusions. Such an expansion may override contract terms and change the benefit design that an employer has selected and paid for. Again, we believe the external review laws should continue to apply to medical necessity issues where there can be differing medical opinions, based on the individual clinical situation of a patient and what is appropriate treatment, based on the patient's condition, in view of latest medical advances, clinical trials, and other relevant medical factors, and not to clear contract exclusions applied uniformly to all insureds covered the policy.

Another major impact is that this bill changes the definition of utilization review to include retrospective reviews. This change will dramatically increase the number of entities that will need utilization review licenses. The Department does not believe this expansion is needed because existing laws (Section 38a-478m and 478n, C.G.S.), already provide requirements for retrospective reviews involving medical necessity. With this change, all insurance carriers that write health insurance in the state and entities that process claims will now require a utilization review license. This potentially increases the number of applications processed annually from 120 to more than 500 and will require additional resource to the Department for the licensing, annual data collection, and market conduct examination of these entities.

The requirement that all utilization review determinations be written, albeit well-intended, could delay the notification to enrollees and providers. Currently only denials are required to be in writing. Approvals require a confirmation number, but may be transmitted other than in writing, such as by telephone, facsimile, or email. This enables the enrollee and provider to immediately begin the approved treatment.

The Department is particularly concerned about the written requirement for expedited reviews in life-threatening situations where time if of the essence, and again a faster approval can lead to immediate treatment. (Note: the Department recognizes that the bill permits a utilization review entity to do an optional non-written notice in addition to the required written notice, but we are concerned that many entities may not do both). The Committee should be aware that Raised Bill 959, the Department's proposal on External Appeals includes provisions related to expedited review.

The bill eliminates the requirement that a copy of the external appeal application and brochure be included with the final denial notice. We believe this change is adverse to consumers, since including the application along with a brochure with the final denial notice allows enrollees to quickly and easily begin the external appeal process. The consumer has a 60 day window to apply for external appeal, and we believe it is prudent for the consumer to act expeditiously and not delay and take a chance on missing the 60 day window. Current law helps the consumer in this regard.

The bill also modifies the external appeals process. The intent appears to be to eliminate the application fee for the enrollee or provider. The Department believes the nominal application fee ($25), except for the indigent, should remain in place to discourage requests that may be unnecessary or without merit for external appeals. There is a cost factor in paying a review entity for each external appeal, and it is desirable to incur such cost only where appropriate and necessary

If this bill moves forward, the Department suggests using the same definition of adverse determination that is in Raised Bill 959. That way the utilization review requirements and the external appeal requirements will be consistent. Final utilization review determinations are eligible for an external appeal, so it is important for the two laws to operate in tandem.

The Department also believes the hearing process, while well-intentioned, raises a host of issues, including: (1) privacy issues, (2) ownership issues, (3) who may access the data, (4) how long must the data be maintained, and, (5) who bears what costs. , etc.

For the reasons noted above, the Department urges the Committee to oppose this bill.